WorkLink

Online Work Status Form for Injured Employee

MEMORIAL HERMANN Health Solutions

Section A - General Information

Injured Worker Name		Claim Number		Date of Injury	
Employer Name		Occupation/Title		Date of Birth	

Section B - Return to Work Status (Please Choose One)

- ☐ Employee can return to work to perform the essential function of the position per the job description as of ______ (Date) **WITHOUT restrictions.**
- ☐ Employee can return to work on a temporary transitional duty basis provided the work is consistent with the activity restrictions identified in Section C: ______ (Date) which are expected to last through ______ (Date).
- ☐ Employee is unable to return to work per the job description ______ (Date) and is expected to last through ______ (Date)

Section C - Employee is released to temporary transitional duty with the following Activity Restrictions (Choose all that apply)

*****Activity restrictions are to be complied with while you are at work and also outside of work.*****

EMPLOYEE IS ABLE TO WORK 4 ☐ 6 ☐ 8 ☐ 12 ☐ TOTAL HOURS PER DAY.

Posture / Motion Restrictions (if any)

☐ Standing		Hrs	☐ Pushing/ Pulling		Hrs	☐ Wrist flexion/ extension		Hrs
☐ Sitting		Hrs	☐ Bending/ Stooping		Hrs	☐ Kneeling/ Squatting		Hrs
☐ Walking		Hrs	☐ Grasping/ Squeezing		Hrs	☐ Overhead Reaching		Hrs
☐ Twisting		Hrs	☐ Climbing stairs/ladders		Hrs	☐ Other		
☐ Reaching		Hrs	☐ Keyboarding		Hrs			Hrs

Driving Restrictions (if any):

- ☐ No driving/operating heavy equipment
- ☐ Night time restrictions
- ☐ Can only drive automatic transmission

Restrictions Specific To (if any):

☐ Left Arm	☐ Left Hand/Wrist
☐ Right Arm	☐ Right Hand/Wrist
☐ Neck	☐ Back
☐ Left Leg	☐ Left Foot/Ankle
☐ Right Leg	☐ Right Foot/Ankle

Medication Restrictions (if any):

- ☐ Medication may make drowsy (possible safety/driving issues)

Misc. Restrictions (if any)

- ☐ Must use crutches at all times
- ☐ at heights or on scaffolding
- ☐ in extreme hot/cold environments
- ☐ No work/ ______ hours/day work:
- ☐ Must wear splint/cast at work
- ☐ Sit/Stretch Breaks of ______ per ______
- ☐ Must keep ______
- ☐ Clean & Dry ☐ Elevated

Lift/Carry Restrictions (if any):

- ☐ May not lift/carry objects more than ______ lbs for more than ______ hours per day.
- ☐ May not perform any lifting/carrying

Other Restrictions if any ______

Section D - Employee Treatment/Follow-Up Information (Fill in or Check all that apply)

Diagnosis Code ______	Diagnosis Desc. ______	Is the injury work related? (Select One) ☐ Yes ☐ No	Is there any further treatment needed? ☐ Yes ☐ No	
☐ The injured employee has reached MMI as of ______ (Date)	If yes, what treatment ______ (please list) and for how long ______			
☐ Follow up visit on ______ (date) at ______ (am/pm)	☐ Diagnostic Study (Please Specify) ______			
☐ Physical Therapy ______ X per week for ______ weeks	☐ Work Conditioning	☐ Work Hardening	☐ Pain Management ______ X per week for ______ weeks	
Physician Name (Please Type) ______	Date of Visit ______	Referral to Specialist ______		
Physician Signature:	Employee's Signature:			

*****Please give a completed copy of the form to the injured worker. Fax the completed report to WorkLink immediately after each visit to (713) 338-6590).*****

***Please fill out all relevant information on the form. Our company takes a proactive approach to returning the injured worker back to work. Utilizing the information on this form, we assign employees to temporary transitional duty work assignments. *Send ALL bills to WorkLink. ***

***Please do not bill or collect any money from the injured employee. *Please call (713) 338-6519 Option 1, then 1 for billing and/or pharmacy information.**

WorkLink 929 Gessner, Suite 1500, Houston, TX 77024

Phone (713) 338-6519 Fax (713) 338-6590